

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18331

State File No. _____

Registrar's No. 11

FILED

MAY 18 1943

195

Registration District No. _____

Primary Registration District No. 5714

1. PLACE OF DEATH:

(a) County McDonalda
(b) City or town Burra Pineville TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Anderson MO. R. # 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 Yrs
years, months or days)

3. (a) Grant Washington, Schlessman
FULL NAME

3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, 2 divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased Feb. 22 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 I 20 hr. _____ min.

9. Birthplace _____ (City, town, or county; State or foreign country)

10. Usual occupation Farming

11. Industry or business First Name Unknown, Schlessman

12. Name _____ 13. Birthplace Unknown
(City, town, or county; State or foreign country)

14. Maiden name Unknown 15. Birthplace Unknown
(City, town, or county; State or foreign country)

16. (a) Informant Robert O. Schlessman
(b) Address Anderson MO. R. # 3

17. (a) Burra (b) Date thereof 4-15-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tracy Cemetery

18. (a) Signature of funeral director Chas. Williams
(b) Address Good MO.

19. (a) May 4 - 1943 (b) Ira Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonalda
(c) City or town Burra
(If outside city or town limits, write "RURAL")
(d) Street No. Anderson MO. R. # 3
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1943 hour 5 minute 30 M.

21. I hereby certify that I attended the deceased from April 12 1943
that I last saw him alive on April 12 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Regard. arterial stenosis with infarction
Due to _____

Due to Heart

Other conditions (Include pregnancy within 3 months of death) B/a

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature W. H. Hester (M. D. or other) ?
Address _____ Date signed 4-14-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 543-611

Date Filed MAY 14 1943

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.